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 **BASICS**

HEALTH IN FRAGILE STATES

COUNTRY CASE STUDY: NORTHERN UGANDA

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Executive Summary

Analysis of Framework Conditions

Uganda can be characterized as a stable country with pockets of fragility that negatively impact security, drain economic resources, and undermine service delivery. Most notably, 20 years of conflict between the rebel Lord's Resistance Army (LRA) and the government-sponsored United People's Defence Forces (UPDF) continue to significantly affect the northern districts of Gulu, Kitgum, and Pader. Ninety-four percent of the population in these districts is displaced in government-established "protected villages," and many of the remaining inhabitants have resettled in municipal areas, which provide greater safety and more economic opportunity. The deterioration of services in rural areas and the potential for disputes over land ownership are two major issues surrounding the eventual return of internally displaced persons (IDPs) to their communities of origin.

Although current fragility is most directly related to military insecurity, political and ethnic factors are key underlying drivers of conflict in northern Uganda. Insofar as politics has been historically treated as a zero-sum game, violence has been frequently used as a means to political gain. Moreover, because the country is largely divided into ethnic regions, perceived ethnic exclusion is a common byproduct of insufficient government response to regional security needs.

Health Service Delivery

Uganda as a whole enjoys a relatively well-developed health service delivery system. Although the government has continued to provide health, education, and other basic social services during conflict in the North, the security situation and related difficulties in recruiting and retaining staff, maintaining structures, and ensuring consistent equipment and drug supplies have severely challenged effective health service delivery. The result has been high morbidity and mortality from preventable and treatable diseases, like malaria and diarrheal illness. In addition, HIV/AIDS is a significant concern in the area.

Crisis Preparedness and Response

At the national level, Uganda lacks an effective service delivery response mechanism for conflict-affected populations. In the Office of the Prime Minister, the Department of Disaster Preparedness and Refugees is mandated to establish policy related to displaced populations, but is not directly engaged in the delivery of humanitarian assistance. At the same time, the Ministry of Health's attempts to coordinate northern-aimed activities with other central level stakeholders—including donors and implementing agencies—have had limited success.

In Uganda's decentralized context, districts are expected to address the management and implementation of crisis preparedness and response functions on the ground. This has proven to be a serious challenge because the districts lack staffing and other capacities. There is no single unifying implementation plan for emergency health service delivery in individual northern districts or across the region. Instead, a patchwork of services across the camps in each district has developed over time. Similarly, neither the government nor the international community has made plans for the eventual return of IDPs to their communities of origin.

State-building by Strengthening the Health Sector

There is a dilemma facing stakeholders who seek to improve the health status of Ugandans living in the North. On the one hand, high excess mortality due to malaria, AIDS, and violence necessitates an emergency response. Local systems face absorption capacity limitations, are considered by some organizations to be too slow, and are beholden to district administrative

systems that can at times be political. At the same time, the only way to improve the government's crisis preparedness and response capacity—at both the national and district levels—is to work through it. Ultimately, genuine investments in both emergency response and local system capacity building are needed.

Most recently, the United Nations (UN) decided to adopt a cluster lead approach in Uganda, with UNICEF taking the lead in health and nutrition. Critically, the Ministry of Health (MoH) and district health teams will be collaborating with other organizations in this effort, but leadership remains with the international community. The Ministry's Health Sector Strategic Plan (HSSP) II calls for appropriate health services in conflict and post-conflict situations through provision of the Uganda National Minimum Health Care Package, yet there is no line item in the current national annual work plan specifically for humanitarian relief and rehabilitation.

At the district level, some international organizations have decided to channel their activities more directly through government services. Although this approach may entail inherent weaknesses in terms of sustainability, it is successful in staffing health units that are otherwise underserved, all without eroding the government's legitimacy as a service provider. This type of innovation appears to be unusual in a setting where direct implementation by outside organizations is more the norm.

Community Capacities and Needs

To create and maintain stability in the North, the issue of perceived ethnic exclusion must be effectively addressed; this is beginning to occur through the Agency for Co-operation and Research in Development (ACORD) Good Governance project and the World Bank-supported Northern Uganda Social Action Fund. Communities also lack a good understanding of the source of services being provided to them and, therefore, have little with which to rebuild trust in the government and in the government's capacity to manage funding opportunities on their behalf.

Perhaps the most promising coalition for improved service delivery in the short term is the deployment of community health workers through the community outreach resource persons (CORPS) and village health teams (VHTs) that collaborate with district health services, as well UN and nongovernmental organizations (NGOs). On one level, these groups may prove to be an important stopgap measure for reaching communities in more remote and under-served areas. At the same time, these mechanisms are intended to be effective health development partners for both the local health services and international implementing organizations in the longer term.

Other Donor Issues

Development funding through national government programs is well established in Uganda and enjoys a certain level of harmonization amongst most donors, but these mechanisms have not effectively addressed the situation in the North. In large part, harmonization is the key to helping the government assume a leadership position with regard to the North and to start building a meaningful emergency preparedness and response capacity at both the national and district levels.

In general, the government and donor community have viewed large-scale health funding in northern Uganda as being outside the regular set of operations. Therefore, donors turn to their implementing partners with a variety of initiatives, depending on what they see as priorities. In response to the January 2006 UN Security Council resolution that called on the government to protect its population and ensure humanitarian access, the Minister of Foreign Affairs recently proposed a new Joint Country Coordination and Monitoring Committee to respond to peace,

recovery, and reconstruction challenges in northern Uganda. It is anticipated that a comprehensive Peace, Recovery and Development Plan for the North will encompass other national initiatives such as the National IDP Policy and the Northern Uganda Social Action Fund.

Recommendations

1. The Government of Uganda has a well-developed policy-making mechanism for emergency response in the Office of the Prime Minister, Department of Disaster Preparedness and Refugees. It lacks the capacity and funding to undertake leadership in implementing emergency programs and therefore relies on the international community to both fund and implement such activities. This erodes legitimacy and does not address long-term capacity issues at the national and district levels. Donors should work with the government to create and maintain an effective crisis preparedness and response system in the health and other sectors.
2. In the short term, the international community must continue emergency support to northern Uganda, as conditions in IDP camps are unacceptable. However, donors should at the same time create stronger funding and program linkages between their development and emergency activities and a transition initiative response that can adapt effectively to the fluid nature of needs in the North.
3. If not addressed now, the perception of conflict-affected populations with respect to the government's willingness to address their needs will become a key issue and will constitute an ongoing driver of instability for years to come. Stakeholders should make explicit efforts to work through government structures by harmonizing plans and finding innovative programming that ensures government "branding" of health services.
4. To create and maintain stability in the North, the perception that northern populations are marginalized must be addressed. Donors should look for innovative initiatives to strengthen the community voice through existing decentralization activities and/or supplementary measures, and enhance efforts by communities to monitor funding income and project outputs according to clear and jointly identified indicators. The international community should specifically support efforts to integrate standardized CORPS and VHT activities into overall relief and development work in the North.
5. Current service delivery difficulties in the North are due, in part, both to the slow-moving nature of the emergency and to the reactive approach of both the government and the international community. Stakeholders must become more proactive. District-level mechanisms should be strengthened to prepare for the eventual return of internally displaced persons to their communities of origin.
6. Harmonization entails donor commitments to joint priority setting and funding sector activities with national governments. The key to success is the translation of donor harmonization, especially in the humanitarian arena, into coordinated programming by the partners. Efforts in this direction must be genuine and with a vision to long-term sustainability at the national and district levels. The donor community should invest the time, effort, and funding necessary to help the government take the leadership that it has called for and that the government is seeking to assume.

Abbreviations

ACF	Action Against Hunger
ACORD	Agency for Co-operation and Research in Development
BBC	British Broadcasting Company
CAP	Consolidated Appeal Process
CMR	crude mortality rate
CORPS	Community Outreach Resource Persons
CSO	civil society organization
CSOPNU	Civil Society Organisations for Peace in Northern Uganda
DAC	Development Assistance Committee
DANIDA	Danish International Development Agency
DDHS	District Director of Health Services
DDMC	District Disaster Management Committee
DfID	Department for International Development-UK
EDA	essential drugs account
EmOC	emergency obstetric care
GAVI	Global Alliance for Vaccines and Immunization
GDP	gross domestic product
GoU	Government of Uganda
HC	health centers
HRW	Human Rights Watch
HSDs	health sub-districts
HSM	Holy Spirit Movement
HSSP	Health Sector Strategic Plan
ICC	International Criminal Court
IDPs	internally displaced persons
INGOs	international nongovernmental organizations
IRIN	Integrated Regional Information Networks of the United Nations Office for the Coordination of Humanitarian Affairs
JCCMC	Joint Country Coordination and Monitoring Committee
Km	kilometer
LRA	Lord's Resistance Army
LTEF	long-term expenditure framework
MFPED	Ministry of Finance, Planning, and Economic Development

MoFA	Ministry of Foreign Affairs
MoH	Ministry of Health
MSF	Médecins Sans Frontières
MTEF	Medium-Term Expenditure Framework
NGOs	nongovernmental organizations
NRA	National Resistance Army
NUSAF	Northern Uganda Social Action Fund
NUSAP	Northern Uganda Social Action Plan
OECD	Organisation for Economic Co-operation and Development
OPM	Office of the Prime Minister
PEAP	Poverty Eradication Action Plan
PEPFAR	President's Emergency Plan for AIDS Relief
PHPs	private health providers
PMTCT	prevention of mother to child transmission
PNFP	private, not-for-profit
RDP	Recovery and Development Plan for northern Uganda
SIDA	Swedish International Development Agency
SWAp	Sector-Wide Approach
U5MR	under-five mortality rates
UCMB	Ugandan Catholic Medical Bureau
UJAS	Uganda Joint Assistance Strategy
UMMB	Ugandan Muslim Medical Bureau
UN	United Nations
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
UNOCHA	UN Office for Coordination of Humanitarian Assistance
UPDA	Uganda People's Democratic Army
UPDF	United People's Defence Forces
UPHOLD	Uganda Program for Human and Holistic Development
UPMB	Ugandan Protestant Medical Bureau
USAID	United States Agency for International Development
USH	Uganda shillings
VHT	Village Health Team

WFP World Food Programme
WHO World Health Organization

All amounts are in US dollars unless otherwise noted.

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1 Analysis of Framework Conditions

1.1 Nature of fragility

Military Insecurity

Uganda can be characterized as a stable country with pockets of fragility that negatively impact security, drain economic resources, and undermine service delivery. The most notable of these is the 20-year conflict between the rebel group Lord's Resistance Army (LRA) and the government army United People's Defence Forces (UPDF). The LRA originated in the central northern region of the country known as Acholiland and, though it has been active in various districts throughout the North, the majority of fighting has taken place in Gulu, Kitgum, and Pader districts. The LRA insurgency began in 1987 under Joseph Kony, who remains its leader today. Kony was a commander in the Uganda People's Democratic Army (UPDA), a rebel group that formed soon after Yoweri Museveni's National Resistance Army (NRA) overthrew the northerner-dominated government of General Tito Okello in 1986.

In the wake of Okello's ouster, two important rebel movements were born: the UPDA and the Holy Spirit Movement (HSM), both of which enjoyed a certain level of popular support. In late 1987 the NRA defeated the HSM, and in 1988 the National Resistance Movement (the political wing that formed from the NRA) brokered a peace deal with the UPDA. The dissolution of both the UPDA and HSM forces within a short time of each other created a power vacuum that the LRA quickly filled. The LRA is characterized by a command structure that relies on a combination of spiritualism and violence to extract a fear-based loyalty from its troops, many of whom were abducted as children. The LRA has never addressed the grievances of northerners with the current government, including disappointment over a broken 1985 power-sharing agreement between the Museveni and Okello, cattle-thieving believed to have been orchestrated by the NRM, and fear of reprisals for Acholi participation in military campaigns of the early 1980s. In its 20 years the LRA has done little to promote Acholi concerns and instead has inflicted intense violence upon the civilian population in the North (Lomo and Hovil 2004). This has served to alienate the LRA from most of the population, although its troops come from the same areas where it operates.

The LRA received at least passive support from the population until 1994, when the Sudanese government began assisting the LRA in retaliation for Ugandan support for the Sudan People's Liberation Army. Violence reached a peak in 1996; much of the population fled into displaced persons' camps, either because of fear of the LRA or due to government coercion. There has been continuous fighting since then, with varying levels of intensity over time. The most recent wave of violence followed an attempt by the Ugandan military, with the cooperation of the Sudanese government, to crush the insurgency through Operation Iron Fist, beginning in March 2002, and Operation Iron Fist II in 2004. The resulting violence was the worst since 1996 and spread into regions that had previously never been touched by the insurgency (Lomo and Hovil 2004).

Today, the government estimates that there are approximately 300 armed LRA rebels operating in the North. Although there has been a documented decrease in the number of LRA attacks over the past months, the LRA enjoy a number of advantages over the UPDF, including the ability to engage the UPDF in small but unexpected tactical maneuvering, strong motivation among the few fighters who remain, and a leadership control system that draws a cult-like adherence from subordinates (Lt. Col. R. Skow, personal communication, April 13, 2006). Rebel attacks against the civilian population are characterized by extreme brutality, often through the use of children that were previously abducted from the same communities. Through such measures, the LRA have established a highly effective terror campaign against its own

populations. While there may be a sense of improved security in some communities (Hovil and Okello 2006; Bøas and Hatløy 2005), during the course of the conflict, many civilians have felt that the UPDF and the government in general have failed to protect them (Human Rights Watch 2005). Relations between the UPDF and communities are strained.

The LRA conflict has also mutually aggravated military situation in southern Sudan and Darfur (Prendergast 2005). Prior to Operation Iron Fist in 2002, the LRA found sanctuary in Sudan. Under Operation Iron Fist and Operation Iron Fist II, the main area of formal cooperation between Uganda and Sudan involved attempts to destroy LRA bases inside southern Sudan. Despite reports of continued small-scale support originating in at least portions of the Sudan, relations between the two countries are good by recent historical standards (Uganda Governance Monitoring Programme 2005). Nevertheless, LRA activity has made humanitarian assistance in southern Sudan more difficult. The rebels have also been implicated in the deaths of eight UN peacekeepers in eastern Democratic Republic of the Congo (UN Office for Coordination of Humanitarian Assistance [UNOCHA] 2006).

Root Causes

While the nature of fragility in northern Uganda is most directly related to military insecurity, this situation is, in turn, linked to two underlying drivers: (1) the historical treatment of national politics as a zero-sum game and the use of violence as a means to political gain; and (2) the division of the country into ethnic regions and resulting perceptions of ethnic exclusion (Lomo and Hovil 2004). The Refugee Law Project elaborated on these themes in “Behind the Violence: Causes, Consequences and the Search for Solutions to the War in Northern Uganda.” The report explains the LRA’s tactics as part and parcel of a post-colonial history marked by bloody coups and armed rebel movements, coupled with very limited accountability for those who have committed extreme violence in the name of political power. In the absence of formal systems to bring perpetrators of violence to justice, successive governments have often used military force to extract revenge on those believed to have been supportive of previous regimes, including civilians. Since support to one regime or another has often been based on tribal allegiances, cycles of attack and counter-attack have reinforced ethnic divisions. This has led to the second root cause of the current instability, namely ethnic marginalization (Lomo and Hovil 2004).

During the colonial era the British employed a “divide and rule” approach in Uganda, based on pre-existing divisions between the North and South. They created an agricultural base in the South, while largely abandoning the North as a region where the different ethnic groups were “. . . unsuitable for rational political administration and economic governance, as opposed to peaceful communities in the south” (Lomo and Hovil 2004, p. 10). While grouping Uganda’s numerous ethnicities into “northerners” and “southerners” is an oversimplified way of viewing the country’s ethnic composition, successive regimes from Idi Amin onward have contributed to a north-south divide by drawing military strength from one region and retaliating against the other. Today’s army may be more balanced than in the past, but no government has effectively addressed the overall gap between ethnicities. Perceptions about which groups are at an economic and/or political advantage color many Ugandans’ view of nationality, and many view the current conflict in the North as an “Acholi” issue. This has allowed for the marginalization not only of Acholis themselves, but also the war. Many Ugandans view the war in the North as an ethnic issue, rather than a national concern (Lomo and Hovil 2004).

Prospects for Peace

In September 2005, the International Criminal Court (ICC) made public indictments for Joseph Kony, who still leads the LRA today, and his senior lieutenants. In October 2005, Senior

Mediator Betty Bigombe declared that the negotiations were over, stating that the LRA leadership would never surrender if they faced an ICC arrest (The New Vision 2005). However, the next month an LRA senior lieutenant asked that peace talks resume. The ICC indictments remain problematic in negotiations (Integrated Regional Information Networks of the United Nations Office for the Coordination of Humanitarian Affairs [IRIN] November 30, 2005).

The LRA's brutality against civilian populations and the tenacity of its fighters have led to a highly effective terror campaign that continues to destabilize the region despite small numbers of insurgents. According to in-country analysis by the U.S. Department of Defense, there has been a marked decrease in security events in the North over the past months (Lt. Col. R. Skow, personal communication, April 13, 2006). However, while the government has said that the war in the North is largely over and is encouraging people to return to their communities, many are still waiting for assurances of both the depth and duration of any improvement in the military situation.

Ultimately, it may prove easier to achieve military security than to address the underlying causes of the conflict. Violence as a means to political power has in recent years been replaced with popular elections, but the specter of a chaotic and bloody past for much of the country is not far behind, and the government has retained a military nature. A reversal of the marginalization of Acholi communities continues to constitute an obvious challenge.

IDP Camps

Currently between 1.8 and 2 million people are internally displaced and living in camps. Of these, 1.2 million are in Gulu, Kitgum, and Pader, comprising 94 percent of the total population of these districts (Civil Society Organisations for Peace in Northern Uganda [CSOPNU] 2006). Although the government's creation of IDP camps as "protected villages" began in 1996, forced population movement stepped up towards the end of 2002, as Operation Iron Fist was well underway. In some cases, civilians were given only 48 hours in which to vacate their homesteads (IRIN 2004). In general, camps were established near trading centers and households that had been clustered in the area occupy villages. The majority of IDPs live no more than 5 kilometers from their original homes. However, curfew and movement restrictions prevent most IDPs from moving more than 1 to 2 kilometers outside of their camp. Two objectives underlie the government's forced migration policy. First, it is theoretically easier to protect civilian populations if they are geographically clustered, and second, it was envisioned to facilitate the routing out of LRA forces with minimized civilian casualties (Patrick 2005). Ironically, conditions in protected villages and IDP camps do not offer adequate protection to the displaced in terms of physical safety, food security, health, or other basic needs. At the time, it was thought that Operation Iron Fist would take no more than six months to carry out and that the displaced would soon return to their communities of origin. For many, however, the security situation actually worsened, and the vast majority of IDPs remain in camps.

1.2 Socio-demographic and cultural context

Uganda is home to 24.6 million people of 50 tribes, none of which has a majority. Nilotic-speaking pastoralists, such as the Acholi, Iteso, Langi, and Karamojong, originated in the North and East of the country. The Kitgum, Pader, and Gulu districts are largely Acholi. The Bantu-speaking agriculturalists are located primarily in the South and West. The British colonial government exacerbated the tensions between these two groups—promoting economic activity in the Bantu regions, while recruiting northerners for military service. The ethnic stereotypes and labels set during this period continue in large part through the present day (World Vision 2005). In 1985, a split between ruling northerners led to the rise of General Tito Okello, an ethnic Acholi. However, his rule was short-lived as the increasingly ineffective and brutal regime fell

before the Museveni-led rebellion in January 1986, and the Acholi soldiers retreated north to begin their insurgency.

The conflict's ethnic aspect thus underlies the current situation, even if the Acholis do not support the LRA. The Acholi resent portrayals of the conflict as being located in an ethnicity rather than in a geographic region, as well as a collective faulting of the Acholi as a whole for the actions of Joseph Kony, himself an Acholi. This political marginalization was exacerbated by the government's forced displacement of civilians, a lack of economic development, widespread suspicions of war profiteering by the senior military officers, and continued insecurity (Lomo and Hovil 2004). If the government does not effectively address these issues at a national level, they may form the basis for continued grievances and perhaps future conflict.

1.3 Economic context

The cost of the war from 1986 until 2002 was estimated at \$1.33 billion or over 3 percent of annual gross domestic product (GDP). The study predicted that a more complete follow-on analysis would suggest the total to be closer to 4 percent of annual GDP. Of this number, 28 percent is direct military expenditures, 16 percent is lost income from crops, 14 percent is lost tourism income, 10 percent is from increased medical costs, and 7 percent is lost output due to ill health resulting from the conflict situation (Dorsey and Opeitum 2002). In March 2006, a study estimated the total economic loss to be \$1.7 billion, which is roughly equivalent to all foreign aid by the United States to Uganda between 1994 and 2002 (CSOPNU 2006). IDPs have almost no access to productive assets or training in the skills that would lead to productive businesses. (UN 2005). While between 1992 and 2000, national levels of absolute poverty shrank from 56 percent to 35 percent; in the same period, absolute poverty in the North fell only from 72 percent to 66 percent. A survey of IDPs in late 2005 found that 68 percent had zero income during the previous month (CSOPNU 2006).

This situation has been worsened by the economic deprivation of the North relative to the country as a whole, the GDP of which grew 6.5 percent annually between 1990 and 2003. (World Vision 2005, p. 31) As much of the population is located in camps, the affected population has largely been unable to generate enough food to survive and is thus reliant on outside food assistance. There has been some improvement in the land situation in the past few years as some IDPs are now able to move within a two-kilometer radius of their camp. In Gulu, the percent of the population dependent on the World Food Programme (WFP) fell from 100 percent to 74 percent by October 2005. However, food cultivation is highly circumscribed as IDPs are subject to nighttime curfews, there is erratic availability of local defense units for protection, IDPs have limited access to both land and agricultural tools, and the LRA or government soldiers occasionally steal crops. Despite some discussion of encouraging the planting of cash crops that rebels would be less likely to steal, no clear action had yet been taken (Hovil and Okello 2006).

Approximately, 23 percent of primary-age children in northern Uganda are not attending school, and 50–60 percent of primary-age schoolchildren in five conflict-affected districts in April 2005 were displaced. (Paul 2006) Furthermore, education services are of a low quality. In Gulu, Kitgum, Pader, Lira, and Apac, 60 percent of the schools are non-functional (Ruaudel and Timpson 2005). A major issue is teacher absenteeism. Donors have been criticized for treating education in the camps as a development issue rather than as a conflict-induced emergency (Hovil and Okello 2006).

1.4 Quality of governance, institutions, and policies

Museveni's victory in the February 23, 2006 presidential elections sharpened perceptions of a north-south divide. The February 2006 elections were preceded by amendments to the

Constitution that allowed a third presidential term and a successful referendum to move from a “no-party” state under the Movement system to a multiparty state in July 2005 (IRIN July 27, 2005). Chief challenger Kizza Besigye of the Forum for Democratic Change, who received 37 percent of the presidential vote nationally, contested the election results. On April 6, 2006, the Supreme Court found that there had been electoral irregularities, but decided four-to-three that these did not affect the election outcome and that the poll results were valid (British Broadcasting Company [BBC] April 6, 2006). While Museveni received 59 percent of the national vote, he performed dismally in the North in what analysts saw as a protest vote against the government’s failure to provide protection (IRIN March 1, 2006). In Gulu, 82 percent voted for Besigye and 13 percent for Museveni. In Kitgum, the percentages were 75 and 19 in favor of Besigye, and 77 percent to 18 percent in Pader. Majority support for Besigye was found throughout the rest of the central and eastern North: 61 percent for Besigye in Adjumani, 57 percent in Arua, 73 percent in Apac, and 80 percent in Lira (Electoral Commission of Uganda 2006).

The elections took place in light of what Human Rights Watch (HRW) described as the increasingly militarization of public office, with multiple high-ranking Uganda Peoples’ Defense Force officers being appointed to civilian positions in the months prior to the election (HRW 2006). HRW also reported the intimidation of and violence against opposition supporters, in particular the Forum for Democratic Change, in all but two of Uganda’s districts. Freedom of expression was severely curtailed; opposition candidates were confronted by obstacles that Movement candidates did not face, and several critical media sources were charged with crimes (ibid.). Pressure on the media continued in the wake of the elections and expanded to include foreign journalists with the correspondent for the Economist expelled in March (The Economist 2006).

The land ownership issue is also a potential area of dispute in the North. So much of the population has been displaced for so long that it is difficult to ascertain the validity of land claims. Similarly, even when the IDPs return home, it is possible that some camps will remain permanent settlements, raising questions about how to handle those people whose original land claims lie within the camps. Tensions around land have been aggravated by widespread rumors that the government has been confiscating the most arable land for itself while the population has been in camps (Hovil and Okello 2006).

Of special interest to the North is the formulation of a comprehensive strategic framework for operationalizing the Internally Displaced People Policy, with the president appointing a senior advisor for the reconstruction of northern Uganda. The first meeting under this policy took place in June 2005. The IDP policy attempts to coordinate existing resources and agencies, rather than creating a new agency. However, by the end of 2005, the government had not allocated resources to implement the policy, nor had coordination meetings been regularized. Also, some conflict-affected districts were unable to spend government funds that had been earmarked for development purposes and were forced to return them to the National Treasury, rather than redirecting them towards humanitarian relief for IDPs (Uganda Governance Monitoring Programme 2005).

However, the IDP Policy, among other programs for northern Uganda such as the Northern Uganda Social Action Plan (NUSAP), is due to be integrated into the Recovery and Development Plan for northern Uganda (RDP). On March 17, 2006, the Minister of Foreign Affairs released the plan for a Joint Country Coordination and Monitoring Committee (JCCMC) on northern Uganda. Besides these two initiatives, in its action plan for March 2006 to March 2009, the government lists its commitment to increase funding to northern Uganda, improve the civilian justice system, strengthen the UPDF, allow the voluntary return of IDPs, improve service

delivery, and engage capacity building for social service delivery by local governments (Ministry of Foreign Affairs [MoFA] 2006).

1.5 Non-state actors

Among the key non-state actors in Uganda are civil society organizations (CSOs), UN agencies, international NGOs, and the international donor community. The country's civil society sector is active in both advocacy and the delivery of services and engages in a wide variety of issues. In the North, a coalition of 50 civil society organizations formed CSOPNU in 2002. It advocates for "just and lasting peace" in the North based on an understanding and articulation of the root causes of the conflict. It recently authored the report, "Counting the Cost: Twenty Years of War in Northern Uganda," which includes recommendations to the government, the UN, and the international community on ways to protect civilian rights.

UN agencies are active throughout the country, and many focus special programs on the North; these include the World Health Organization (WHO), UNICEF, and WFP. UNOCHA has offices in both Kampala and the North. Myriad international NGOs operate throughout the country, many with a field presence in the conflict-affected districts. Indeed, one of the challenges in the North revolves around efforts to coordinate the activities of a vibrant non-state sector.

While civil society organizations and international agencies have been relatively unencumbered by the government in their operations, the donor community has grown increasingly strict in its funding to the country due to concerns about bloated government budgets and general governance issues. In the first half of the 2005/2006 fiscal year, donors cut or withheld \$73 million in aid, with total direct budget support falling from an expected \$194.85 million to \$131.5 million. The relevant donors were the World Bank and the governments of Sweden, the Netherlands, the United Kingdom, Ireland, and Norway (The East African 2006). Much of this was redirected into humanitarian aid in northern Uganda (Human Rights Watch 2006).

1.6 Summary and Conclusions

The current military insecurity in northern Uganda began 20 years ago and was born from both a history of violence as a means to political power and a strong ethnic division between the North and South. Currently, the number of active and armed LRA rebels is relatively small, approximately 300, according to Ugandan army estimates. However, the rebels have evolved a highly effective terror campaign, and 94 percent of the populations of Gulu, Kitgum, and Pader districts are essentially trapped in government-established IDP camps that offer very little in the way of livelihoods, limited physical security, and poor overall living conditions.

Economically, the war in the North cost the country \$1.33 billion between 1986 and 2002. The development of conflict-affected districts has been severely hampered by insecurity. Internally displaced populations have very limited access to crop cultivation, and the vast majority is dependent on food distribution that the international community provides.

There has been a marked decrease in the number of security incidents in recent months, and there is hope that this marks the beginning of the end to the war. The government in Kampala is encouraging IDPs to return home, but UPDF forces in the field have not yet advised the same. Many see the recent decreases in violence as tenuous since the conflict has been characterized by swings in security. For now, most people in the North have adopted a "wait-and-see" approach. Ultimately, the end of the war might only be signaled by the incapacitation or capitulation of LRA Leader Joseph Kony, who remains at large. Even if an official peace comes to the communities of the North, long-term instability may afflict both the region and the country if the underlying drivers of fragility, namely political power through violence and ethnic marginalization, remain unresolved.

2 The Health Sector

2.1 Health system organization and infrastructure

The Health System's Organization and Structure

Until fairly recently, the Ugandan health sector was highly centralized, with the national Ministry of Health (MoH) retaining control over all management functions. In the last decade, however, the country has taken steps to restructure the national health system and has decentralized all service delivery activities to the district level. The central MoH is now responsible for policy formulation; setting standards and quality assurance; resource mobilization; capacity development and technical support; epidemic control; and monitoring and evaluation of overall sector performance. Other national level institutions include the National Referral Hospitals, National Drug Authority, and Regional Referral Hospitals, which are either autonomous or have self-accounting status.

The district health system is considered to be a self-contained segment of the national system, with district health management teams responsible for planning, budgeting, and monitoring district performance (MoH 2005a). Each district is divided into health sub-districts (HSDs), which are functional service zones responsible for the delivery of a basic package of health services. There are four levels of district facilities: referral facility (general hospital at the district level or health center IV at the county level); health center III at the sub-county level (covering a population of 20,000); health center II at the parish level (for a population of 5,000); and health center I, operated by village health teams, serving a population of 1,000 (MoH 2005a). While the MoH reports that the HSD structure has been established, many HSDs are not yet fully functional, and their limited operational capacity has resulted in lower than expected performance overall (MoH 2005a). In particular, the northern districts are limited by severe human resource and infrastructure constraints.

Infrastructure and Health Facilities

According to the Ministry of Health, there are an estimated 1,738 health facilities in the entire country, including 1,226 that are government owned, 465 that belong to NGOs/private not-for-profits, and 47 that are operated by private health practitioners. These include 104 hospitals (57 government, 44 NGO, and 3 private), 250 health centers (179 government, 68 NGO, and 3 private), and 1,384 other facilities (990 government, 353 NGO, and 41 private) (MoH website 2006). A May 2005 survey of private health providers (PHPs) estimated that there was a total of 2,154 PHP facilities in the country (Mandelli et al. 2005).

There is an unequal distribution of health facilities across regions and rural-urban areas. Colonial-era health infrastructure was predominantly clustered in the central, southern, and eastern regions, with much less infrastructure in the North (Carlson 2004). Health infrastructure is especially poor in the rural areas, where 95 percent of the northern population lives; more than half of rural health facilities have been closed down or remain only partly functional (Consolidated Appeal Process [CAP] 2006). MoH 2002 data reveal wide variations in accessibility across districts, with the northern districts of Kotido, Kitgum/Pader, and Gulu having the most limited access (7.1%, 13.1%, and 32.6% of the population, respectively, within 5 kilometers of walking distance), compared to a national average of 72 percent and near 100 percent in the districts of Jinja, Tororo, and Kampala (MoH 2005a). Since 2001, there have been efforts to upgrade and construct new facilities in the country; however, many of the new health units have been reported to be non-operational due to a lack of staff and of equipment (MoH 2005a). Access to referral facilities in the North is also extremely limited and non-existent

in some rural areas. For the most part there are few ambulances, and private transport is outrageously expensive due to the security situation (Médecins Sans Frontières [MSF] 2004).

Human Resources

The MoH reports that there are approximately 30,000 trained health workers in the public health sector, a number acknowledged as inadequate for the delivery of the basic health care package. In general, the health sector workforce is characterized by unequal distribution of staff and inappropriate skills–mix. The proportion of approved posts filled by trained health workers was 68 percent in the country, with coverage of individual districts ranging from 26–263 percent. A 2004 HRH inventory indicated that 65 health centers (HC) IIs were not staffed at all and that only nursing assistants staffed about 30 percent of HC IIs (MoH 2005a).

In the northern districts, MoH staffing levels are grossly inadequate; facilities are chronically understaffed and dominated by lesser-skilled health care workers. A very low proportion of the already-limited facilities are actually filled by appropriate health staff; in Pader it is 45 percent, Kitgum 47 percent, and in Gulu 60 percent (WHO January 2006). The proportion of PHP facilities owned by clinical officers (27%) is considerably higher in the northern region compared with the rest of the country, where medical officers own the majority of PHP facilities (Mandelli et al. 2005). The highly insecure working conditions have led to the flight of trained professionals and impeded the retention and recruitment of skilled health personnel. Some rural health centers are reported to have little or no staff. Where staff are posted to rural health units, they often commute from the district headquarters or work for less than three days a week (WHO January 2006).

Drug Supply and Management

A National Drug Policy was developed in 2002, and a five-year National Pharmaceutical Sector Strategic Plan is currently being implemented. Efforts in recent years have included revising the drug ordering system to an order-based system and establishing a central essential drugs account (EDA) to integrate all funds for public sector essential medicines and health supplies procurement (MoH 2005a). The Health Sector Strategic Plan II notes that drug management and procurement have been complicated by initiatives such as the Global Fund and the President's Emergency Plan for AIDS Relief (PEPFAR). At local government levels, the large number of vacant pharmaceutical posts and insufficient training of other health workers hamper drug supply management (MoH 2005a). Many northern districts depend largely on humanitarian assistance for drugs and other supplies.

2.2 Health care providers and service delivery

Health service provision in the northern districts has been severely disrupted, leaving much of the population's most basic health needs unmet. Health service delivery consists mostly of externally supported NGO projects, focused on responding to the most urgent humanitarian needs and major causes of morbidity. The availability of health services is fragmented and unevenly distributed across districts and rural-town areas (CAP 2006). Much of the population in the conflict-affected areas are crowded into some 200 congested IDP camps, with appalling water and sanitation conditions and poor basic health services. Access to conflict-affected areas is limited, and armed escorts are required to reach displaced populations in some areas. As a result, service delivery is erratic, with frequent closings of peripheral health units, the exclusive use of mobile clinics in some areas, and a total lack of service provision in others (WHO February 2006; CAP 2006; MSF December 2004).

Government service provision is confined largely to the towns where regional referral hospitals are located. District-level administrative structures remain functional in the North, with district directors of health services and health management teams continuing to oversee service delivery within the national policy framework. However, their operational capacity is severely restricted by human resources and financial and security constraints. District health systems are not equipped or sufficiently developed to respond to the enormous numbers of chronically displaced persons located in camps outside the town centers. Government units have not been financed to support mobile clinics capable of reaching the population (WHO January 2006).

Uganda has a large, private, not-for-profit (PNFP) health sub-sector, including many facilities run by sectarian organizations, such as the Ugandan Catholic Medical Bureau (UCMB), the Ugandan Protestant Medical Bureau (UPMB), and the Ugandan Muslim Medical Bureau (UMMB). Non-state health providers play an important service delivery role, accounting for an estimated 60 percent of health services in the country, of which PNFP hospitals and health centers delivered 30 percent. The government has incorporated PNFP providers into the national health system and provides some budget support to PNFP facilities. In Gulu district, the high-performing PNFP Lacor hospital has continued to function and provide regional referral services throughout the conflict (Hauck 2004).

In addition to established PNFP actors, a large number of local and international humanitarian NGOs are providing basic health care in the absence of effective government service provision. Poor coordination among actors and operational constraints have led NGOs to concentrate services near district towns, with little support reaching the more rural camps. Gulu District is reported to have more than 200 organizations present, while Pader District (created in 2001) has received more sporadic assistance. (WHO February 2006; CAP 2006; MSF December 2004). INGOS focus on basic health service delivery, including running health centers, nutrition, and therapeutic feeding programs, trauma care, and hospital support. UN agencies, including WHO, UNICEF, WFP, United Nations High Commissioner for Refugees (UNHCR), and United Nations Population Fund (UNFPA), and local civil society organizations also provide critical health service delivery support.

With high HIV/AIDS prevalence in the region, prevention and care activities are top priorities. According to the most recent CAP, there has been an increase in HIV/AIDS-related services in the last year, including prevention activities, targeted support for orphans and vulnerable children, food distribution, and provision of anti-retroviral therapy in some districts. ART is now offered in regional and PNFP hospitals in Gulu, Lira, Pader, Kitgum, Adjumani and Katakwi. Some district and regional hospitals also provide HIV/AIDS counseling and testing and prevention of mother to child transmission (PMTCT) services (CAP 2006). AVSI has been operating a PMTCT program in Kitgum and Pader since 2002 (WHO May 2005).

2.3 Financing and financial management

The national health system is financed by the central government budget (including donor budget support and project funding), local government and parastatal contributions, PNFP agencies, private firms, and out-of-pocket expenditures (MoH 2005a). Since 2000, the government has had a health sector-wide approach (SWAp), with several donors providing direct budget support. The country has developed long- and medium-term expenditure frameworks (LTEF/MTEF) and an annual budget framework paper for the health sector (ibid.).

Government health expenditures have increased in recent years, rising from 7.6 percent of the government budget in 2000/01 to 9.6 percent of the budget in 2004/05, representing current spending of approximately \$9 per capita. However, only about 30 percent of the first Health Sector Strategic Plan was funded. The Ministry of Finance, Planning, and Economic

Development (MFPED) has set expenditure ceilings for sector budgets in the MTEF, under which donor project funding is supposed to be included. MTEF policy is that donor project funding and global funding initiatives displace GoU funding (*ibid.*). The GoU has also developed a fiscal decentralization strategy, with plans to increase the proportion of resources allocated to district health services.

Global health initiatives have provided significant support to Uganda, including \$213.6 million approved for HIV/AIDS, tuberculosis, and malaria from the Global Fund, \$86.5 million for five-years from the Global Alliance for Vaccines and Immunization (GAVI), and \$409 million from PEPFAR. Some of these resources are being directly disbursed at the district and local levels.

Private out-of-pocket spending accounts for around half of total health expenditures in the country (MoH 2005a). Cost-sharing of health services was introduced in the 1990s, however, complaints led to the abolishment of user fees in government-run facilities in March 2001, with the exception of user fees in private wings of hospitals. The government also provides subsidies to PNFP facilities to ensure that user fees are kept low (Derriennic et al. 2005; MoH 2005a).

Social health insurance plans are to be phased in starting with those employed in the formal sector. Community-based health insurance schemes have been undertaken, but have generally suffered from low recruitment and retention rates. No community health financing schemes have been introduced in the conflict-affected northern districts, with the exception of a health insurance scheme at Lacor hospital, which serves a very poor population and is supported by external donor funding (MoH 2005a; Derriennic et al. 2005).

Northern districts receive ordinary government budget support, but this has proved inadequate for responding to the complex humanitarian situation. Project aid, primarily in the form humanitarian assistance from external donors, I/NGOs and UN agencies, remains the principal funding source for most health service delivery in northern Uganda.

2.4 Stewardship

National health policy and planning were virtually non-existent until the government developed its first national health plan in 1993. Health sector policy in the 1990s set out plans for service delivery decentralization to the district level, introduced cost-sharing schemes, and included plans for integrating the significant private for-profit and non-profit sectors into the national health system. Since then, the government has continued to initiate a series of health sector reforms, the most significant in 2001, which repealed user fees in government-run health centers and allowed for increased support to districts.

The third Poverty Eradication Action Plan (PEAP) 2004/05–2007/08 provides the overarching strategic framework for development. The 1999 National Health Policy and the five-year Health Sector Strategic Plan, Phase II 2005/06–2009/10, also guide health sector planning and management. These documents focus on the development of district health systems for the provision of a minimum health care package; capacity building and the development of human resources for health; and support for HIV/AIDS prevention and care. Stated priorities are the provision of cost-effective, integrated, high-impact health services that make the largest contribution to reducing the leading causes of mortality and morbidity (MoH 2005a). Since 2000, the SWAp process provides a single framework for sector planning, budgeting, reporting, and monitoring and evaluation. Annual joint review missions monitor sector performance and set strategic priorities.

To address the situation in the North, the government has undertaken a number of health policy and planning processes:

- The National Policy for Internally Displaced Persons states that the MoH and local governments are responsible for ensuring that all wounded and sick IDPs receive necessary medical care and that the government is also responsible for providing clean and safe water to displaced persons.
- The 2004 Recovery and Development Plan for Northern Uganda acknowledged the existence of an emergency situation requiring urgent intervention in the North, but noted that the “government has not neglected to provide for the North throughout the period of conflict in the region.” The document specifies that 24 percent of local government grants in the health sector were distributed to the North, on par with 28 percent to the West, 27 percent to the East, and 20 percent to the central regions (Office of the Prime Minister [OPM] 2004).
- The Health Sector Strategic Plan II acknowledges the special challenges faced in the conflict-affected areas and briefly outlines strategies including mobile primary health care units and increased support to CORPs and VHTs (MoH 2005a).
- Other measures taken by the GoU include establishing a National Committee for AIDS in Emergency Settings in 2005, charged with developing a strategic plan for HIV/AIDS in the North.

The government has been criticized by some partners for its reluctance to declare northern Uganda a disaster zone and initiate and fund an appropriate response (Carlson 2004). The 2006 WHO strategy notes that, “despite the protracted crisis, health planning has failed to shift to an emergency mode that would address the most urgent needs” (WHO 2005a and 2006b). Like many developing countries, emergency response systems are limited, and district level actors are stretched thin in their efforts to implement government policy commitments. While the district disaster management committees (DDMCs) in the northern districts are operational and receive standard budget support, they face a formidable challenge in trying to effectively coordinate hundreds of initiatives that, over time, the international community has established more often than not in parallel to local systems. The 2006 CAP strongly emphasized the need for the GoU to lead the humanitarian response and development of the Common Humanitarian Action Plan, and that district priorities should drive humanitarian planning and that the planning should occur under existing district structures. In practice, however, this also depends on the ability and willingness of international partners to harmonize their efforts with government processes. While efforts in this direction have begun, so far the alignment of stakeholder programs has been difficult to achieve.

In response to the January 2006 UN Security Council resolution which called on the government to protect its population and ensure humanitarian access, the GoU Minister of Foreign Affairs has recently proposed a new Joint Country Coordination and Monitoring Committee to respond to peace, recovery, and reconstruction challenges in northern Uganda. It is a government mechanism with proposed core team members to include the Office of the Prime Minister and Ministries of Defence, Internal Affairs, Finance, and Foreign Affairs, with additional representatives from Core Group Countries, the UN, and NGOs/CSOs. It is anticipated that a comprehensive Peace, Recovery and Development Plan for the North will encompass other national initiatives such as the National IDP Policy and the Northern Uganda Social Action Fund (NUSAF). The government also voiced a commitment to increase funding for northern Uganda through the national budget, including a specific allocation within the MTEF FY 2006/07–2008/09 (MoFA 2006).

2.5 Community engagement

The health structure provides for the participation of local communities in health sector planning and implementation via VHTs. Each village will select its VHT; each VHT is charged with

identifying needs, community mobilization, selection and oversight of community health workers, and serving as a link between the community and health providers. However, according to the HSSP II, “the establishment of the Village Health Teams has been slow and not well coordinated. There are health workers in the community supported by different programs and the connection between the multiple community health initiatives and HSSP is not always evident. The linkage with the formal health system and the community remains weak” (MoH 2005a).

Community-level treatment of fever/malaria, diarrhea, and pneumonia is a key strategy emphasized in the HSSP II, particularly in the northern districts that are experiencing a health personnel shortage. CORPs is composed of community members who have been trained in home-based management of fever and can provide some treatment (Homapak). Some were also trained on an expanded home-based care program to manage common health problems of children under five and dispense other basic medications (WHO April 2005).

Successful community participation schemes have been implemented in the country, with the Luweero district (central region) community-based health financing schemes documented as good practice (Kiwauka-Mukiibi et al. 2005). However, no such schemes have been attempted in the northern districts, and there is little information on other demand-side initiatives.

2.6 Health service outputs and outcomes

Available health data for the northern districts are limited largely to humanitarian estimates of morbidity, mortality, and nutritional status, with surveys repeatedly showing that the population is worse off than other parts of the country. In some areas, it is estimated that some 51 percent of households do not have access to basic health care (WHO January 2006). Conditions vary across locations, with the most conflict-affected Acholi sub-region and the frequently drought-affected Karamoja sub-region generally having the worst health indicators. In July 2005, the MoH commissioned a health and mortality survey among IDPs in the three most conflict-affected districts (Gulu, Kitgum, and Pader); the survey data are provided below.

Utilization is believed to be generally poor across the region, although there is considerable variability across areas due to supply-side factors. Access to health services is generally poor, with less than 30 percent of the Acholi population living within a five-kilometer (km) radius of a functional health unit. According to the 2006 CAP, only 41.7 percent of deaths in the sub-region occurred in health facilities. The 2005 MoH/WHO survey found that the majority of ill children (96.5%) were reported to have received treatment from at least one source, including health centers, private clinics, drug stores, and community outreach resource persons; 18.6 percent sought treatment from a second source. Only 15.1 percent of cases sought treatment from CORPs.

Immunization rates are thought to be very low in the northern districts. Combined caregiver-reported and card measles vaccination coverage for children 9–14 years ranged from 85.1 percent in Kitgum to 94.8 percent in Gulu; however, only 23–29.2 percent of children actually had vaccination cards. **Bednet coverage** among children under five ranged from just 25.5 percent in Gulu district to 31.2 percent in Pader, with a total of 60.1 percent of households in the surveyed area not owning a bednet (MoH/WHO 2005).

There are few estimates of **antenatal coverage** or **skilled birth attendants** in the northern districts. The country as a whole reports near universal first antenatal attendance but the proportion of women who complete four attendances and deliver in health facilities remains much lower (MoH 2005a). In Gulu district, antenatal attendance is reported to be high, but a very low number of women deliver in health facilities (WHO 2005a). Access to basic emergency obstetric care remains extremely low, at 5.1 percent nationally. A national government survey

on emergency obstetric care (EmOC) found that only 14 percent of 592 facilities surveyed offered EmOC services and 33.3 percent of hospitals and 90.1 percent of HC IVs did not meet criteria for adequate EmOC (MoH 2005a).

Nutritional status in the region has improved slightly, although it still remains an acute problem in some areas. Assessments have shown global acute malnutrition rates of 18.7 percent in the Karamoja sub-region, 6.2–10.2 percent for Gulu district, 11.8–15 percent in Kitgum, and 5–10 percent in Pader. A 2003 ACF survey found chronic malnutrition of 41.4 percent in Gulu district (ACF 2003; MSF December 2004; CAP 2006).

Northern Uganda has higher **HIV/AIDS prevalence** than the national average, with 9.1 percent on average compared to 6.2–7 percent nationally (MoH 2005b). Sentinel surveillance data from Lacor Hospital in Gulu indicated prevalence of up to 11.8 percent among pregnant women (WHO January 2006; WHO 2005a).

Crude and under-five mortality rates (U5MR) have been measured above emergency thresholds in some northern districts, reflecting a threatened health and security situation.

The 2005 MoH/WHO survey in the Acholi districts found crude and under-five mortality rates of 1.54/10,000/day and 3.18/10,000/day, respectively. Malaria/fever, AIDS, and violence were the major self-reported causes of death (MoH/WHO 2005). Although various stakeholders have debated the survey results and the methods used, a picture of poor health conditions in the IDP camps remains clear. A 2004 assessment in the Karamoja sub-region revealed a crude mortality rate (CMR) of 3.9/10,000/day (MoH 2004). MSF mortality surveys conducted in Soroti town in 2003 estimated a CMR of 4.2/10,000/day and a startling 10.4/10,000/day for under-fives; 75 percent of adult deaths during the survey period were directly related to violence (MSF December 2004; Nathan et al. 2004). Other MSF surveys in 2004 in five IDP camps in Lira district revealed a CMR of 2.8/10,000/day for the general population and 5.2/10,000/day for children under five, with a U5MR as high as 10.5 in one area. The main causes of mortality here were malaria and diarrhoea (MSF December 2004). The MoH estimates a **Maternal Mortality Ratio** of 600–700/100,000 live births in the Acholi sub-region.

There is limited data available on **psychosocial outcomes** among the population in conflict-affected areas, but a 2003 MSF survey in Pader found high levels of suicidal ideation, especially among females; 62 percent of all women interviewed reporting to have thought about suicide in the last seven days (MSF-Holland 2004).

2.7 Summary and Conclusions

While Uganda as a whole enjoys a relatively well-developed health service delivery system, massive population dislocation and difficulties in staffing health units in insecure areas are major hindrances to the government in providing health care to the conflict-affected districts. The government's capacity to respond effectively in the North is also complicated by the considerable challenges of coordinating international emergency efforts in the area.

Government financing for health services in the North include both the regular mechanisms through the Ministry of Finance, Planning and Economic Development, as well as any special initiatives from outside sources channeled directly to the districts. At the national level, however, the health sector's budget is under-funded. Given that much of health financing in the North occurs in parallel to the government, it is difficult to assess actual per capita health spending in the area. While more funding may be needed, a better-coordinated response across all stakeholders would also likely yield health service delivery improvements.

Despite various efforts by the government and non-governmental sectors, food security, water and sanitation conditions, and chronic protection concerns have negatively impacted the population's health status. Much of the population has only minimal access to basic health

services and suffers high morbidity and mortality from preventable and treatable diseases such as malaria and diarrheal diseases. In addition to these basic causes of death and illness, HIV/AIDS is a significant concern in the area. Treatment is available through some outlets in municipal areas, but much of the population lack access to testing and care services.

3 The Role of International Development Partners

3.1 Inventory of key actors

A wide variety of key actors support development programming in Uganda. In the health sector, international donor agencies provide funding:

1. Directly to the government through debt relief, budget support (SWAps), and earmarked support;
2. To the government (both central and district levels) through specific project support; and
3. To the non-profit private sector.

These sources complement the GoU investments in health. For FY 2004/05, government health sector expenditures were estimated at Uganda shillings (USH) 219 billion (approximately \$127 million), representing about 11 percent of the total government budget, while the MoH estimated donor project expenditures to be USH 255 billion (approximately \$147 million) (MoH 2005c, pp. 57–58).

Table 1. Key actors in health sector support (ibid.)

Donor support to government	<i>Multilateral Debt Relief (all sectors)</i>	International Monetary Fund and International Development Association
	<i>SWAps</i>	Netherlands, Sweden, European Union (EU), Ireland, Norway
	<i>Earmarked Support</i>	Sweden, EU, UK, Belgium, Ireland, France, Italy, Denmark, Norway
Donor projects and global initiatives (FY 04-05)	African Development Bank, Danish International Development Agency (DANIDA), Ireland, UK, EU, Italy, Sweden, UNFPA, UNICEF, United States Agency for International Development (USAID), WHO, World Bank	
Donor support to the non-profit private sector	USAID, EU, Development Cooperation Ireland, Italian Cooperation, WHO, UNFPA, DANIDA, Swedish International Development Agency (SIDA)	

USAID health sector activities fall under its human capacity program and focus on efforts to control infectious disease, improve child survival health and nutrition, reduce the transmission and impact of HIV/AIDS, and reduce unintended pregnancy and improve healthy reproductive behavior.

In addition to the above, various global initiatives identified in chapter 2 are currently being implemented as well as large-scale donor programs specifically for northern Uganda including:

- *Northern Uganda Social Action Fund (World Bank) 2003-08*. Total funding: \$100,000,000. Purpose: Enable communities in northern Uganda to identify, prioritize, and plan their needs and implement activities to improve socio-economic services and opportunities. (World Bank)

- *European Union Acholi Project 2001-05*. Total funding: 4 million euros. Purpose: Capacity building of local governments in dealing with social service delivery and financing of social infrastructure (schools, health centers, water) in sub-counties through the District Development Plans (European Commission Delegation to Uganda).

The European Commission plans to further support rehabilitation activities in the North through the Northern Uganda Reconstruction Project.¹

3.2 Approaches to harmonization and alignment

National Level Coordination and Harmonization: Development programming for health

All stakeholders—government, donors, and implementing partners—at both the central and district levels have highlighted coordination and harmonization in both development and humanitarian initiatives as key issues of concern.

Coordination involves primarily information sharing; numerous mechanisms exist for this purpose. Examples of coordination fora for general health program planning (development) at the national level include:

- Joint Review Mission (meets annually, chaired by the MoH, with participation from districts)
- National Health Assembly (meets annually, chaired by the MoH, with participation from districts)
- Health Policy Advisory Committee (meets monthly; chaired by the MoH, with participation from donors)

Harmonization entails donor commitments to joint priority setting and funding of sector activities with national governments. In Uganda, national level government planning and budgeting for development activities (all sectors) takes place through the PEAP and MTEF. The Ministry of Finance, Planning, and Economic Development leads this process with participation from a wide variety of donors that commit budget and/or project support to the plan. In addition, the World Bank, the African Development Bank, and several European donors fund partial implementation of the PEAP through the Uganda Joint Assistance Strategy (2005–09) (UJAS).

The UJAS has three main principles including: (1) support to the government-led PEAP to achieve the Millennium Development Goals; (2) more effective collaboration among donors and between donors and the government, and; (3) a focus on results and outcomes (Development Assistance Committee-Organisation for Economic Co-operation and Development [DAC-OECD] 2005). The Joint Country Coordination and Monitoring Committee on Northern Uganda (described in section 2 of this paper) refers to arrangements for a specific allocation to northern Uganda through the MTEP (2006/07–2008/09).

In terms of development funding to the health sector specifically, additional health planning coordination is undertaken through SWAps. Since 2001, several major donors have channeled the bulk of their health sector investments through the Ministry of Finance, Planning, and Economic Development to support stability and consistency of the government's health budget for more effective long-term planning. From the Government of Uganda's perspective, budget support is the preferred financing mechanism; several European donors also favor it. Harmonization of donor funding and government investments is afforded through a single joint

¹ Interview with Morten Petersen, Head of Office, European Commission Humanitarian Aid Office (ECHO), Kampala, Uganda, April 12, 2006.

planning and monitoring system. In 2005, donors and the Government of Uganda held a review of the first five years of SWAPs to identify issues for further streamlining. The review results were highlighted in a Joint Action Plan for Alignment and Harmonization.

While USAID engages in a variety of coordination fora and communicates regularly with both the MFPEd and the MoH about its health sector investments in the country, it does not participate in aid harmonization efforts such as SWAPs, and the MoH and at least one donor noted the practical difficulties of not knowing either how much USAID funding is to be made available or what it will be spent on, in advance of the rest of the budgeting and planning process. Similarly, although appreciating the specific contributions of global initiatives such as GAVI, the Global Fund, and PEPFAR in addressing certain population health concerns, the MoH does note these to be out of line from the underlying principles of SWAPs, which include lower transaction costs, clear national ownership, government capacity building, and sustainability (MOH 2005c).

National Level Coordination and Harmonization: Humanitarian Response

One of the resolutions at the first National Health Assembly and 9th Joint Review Mission in November 2003 called for the Ministry of Health to “. . . bring together Partners to encourage comprehensive health sector support to districts with insecurity, including health services for IDPs” (MoH 2004, p. 2). However, when the Ministry of Health called for a meeting to discuss planning for health services for the IDPs in 2004, mainly government representatives attended it, and there was little opportunity to coordinate with other stakeholders.² The Ministry of Health does not have a department that specifically addresses refugee or displaced population health needs as these are to be handled at the district level. The MoH Health Sector Strategic Plan II (HSSP II) calls for appropriate health services in conflict and post-conflict situations through provision of the Uganda National Minimum Health Care Package, (MoH 2005a), however, there is no line item in the current national annual work plan specifically for humanitarian relief/rehabilitation. While there is a budget section for public health emergencies that mentions displaced populations, activities are geared more towards addressing potential natural disasters and specific disease outbreaks such as Ebola and totals approximately \$122,000 for the country.³ MoH annual district budget allocations do take into account the specific considerations and characteristics of the districts, including such factors as poverty levels, remoteness, and the existence of IDP and/or refugee populations. In this way, the government tries to ensure that sufficient resources are available to districts that have special needs. In the 2002–03/2003–04 health budget allocation by district, Pader District came out on top and Kampala District on the bottom.⁴

The OPM Department of Disaster Preparedness and Refugees, which has the overall government mandate to establish policy related to displaced populations, is not directly engaged in humanitarian assistance delivery. To date, primarily the international donor and implementing agencies have been coordinating services to northern Uganda.

Among donors and international agencies at the central level, until very recently, harmonization of the humanitarian response for northern Uganda has been weak. As further described below, duplication of efforts and unequal distribution of services across IDP camps is a significant

² Interview with Christine Kirunga, Health Planning Department, Ministry of Health, Kampala, Uganda, April 7, 2006.

³ Government of Uganda, Ministry of Health, “Annual Work Plan for FY 2005/2006,” pp. 36-37.

⁴ Interview with Christine Kirunga, Health Planning Department, Ministry of Health, Kampala, Uganda, April 7, 2006.

concern. UNICEF is spearheading an exercise that will map out all of the health service delivery points in the IDP camps of the northern conflict-affected districts. This is the first time that such an exercise will be done. Until now, there has been no comprehensive picture, even within the international community, of which organizations are providing services at which locations. Coordination meetings under UNOCHA do occur at the Kampala level, and UNICEF also co-chairs a monthly health and nutrition sector meeting with the Ministry of Health. However, these are mainly for information-sharing purposes only (e.g., results of surveys and studies, plans for rollout of new anti-malarial protocols, other technical discussions, and so on) and do not result in one common work plan between agencies.

As part of its FY 2005 funding of humanitarian activities, the Department for International Development (DfID) has set aside \$11.7 million to be spent in a six-month period through a project to be managed by UNICEF on behalf of all of the relevant UN agencies. These funds will be used to implement humanitarian programs by both district authorities and NGOs in a number of sectors including health. SIDA will complement this amount with an additional \$6 million for the following six months. From the UN (UNICEF) perspective, this will be an effective coordination mechanism, as it will bring key stakeholders to the same table. The cluster lead approach is another attempt by the international community to better coordinate the northern Uganda response. Uganda is one of three countries where the UN is piloting this strategy under which UNHCR will serve as the lead organization for IDP camp management. UNICEF will have responsibility for the health sector across all camps.

District Level Coordination and Harmonization

At the district level, a wide variety of organizations are funding and/or implementing activities in the IDP camps, although there are more such initiatives in Gulu than either Kitgum or Pader. In Gulu District it is estimated that there are over 200 organizations present. The Office of the Prime Minister, Department of Disaster Preparedness and Refugees seeks to address coordination of relief efforts in northern Uganda through a DDMC in each of the affected districts. The DDMC consists of district government, UN, and NGO members and has a number of sectoral committees including both health and nutrition, and HIV/AIDS. In Gulu District the DDMC Chairperson and the UNOCHA representative co-chair this committee. The sectoral committees meet on a monthly basis, and the DDMC meets quarterly. The DDMC and its sectoral committees (in Gulu) have served more an information sharing function so far than as facilitating joint planning, and frequently incomplete attendance works against the purpose of the meetings. As the UN and NGOs have their own funding sources and work plan agreements with their respective donors, practical coordination through joint planning for the rational distribution of services across the district has remained a challenge.

A key underlying reason for the lack of coordination on the ground lies in the historically slow-moving nature of the current humanitarian crisis. In contrast to an incident-specific emergency (e.g., a natural disaster such as earthquake or tsunami, or an abrupt eruption of conflict such as occurred in Rwanda), which may benefit from an immediate, large-scale international response coordinated by key players on the ground, the situation in northern Uganda has evolved slowly over time, at one point labeled a “silent emergency.” International organizations and donor funding eventually began to address the needs of the affected populations in the manner thought by each to be most appropriate with whatever funding was available. A variety of programs are implemented within the same setting—some more development-oriented and others more humanitarian in nature. These factors have created a patchwork approach to service delivery that is today difficult to organize into a coherent framework.

To some extent, the coordination level for humanitarian and development activities at the district level depends not only on the number and nature of organizations providing services, but also

on local leadership. In Gulu District for example, the district director of health services (DDHS) has been proactive in trying to establish coordination through his role in the registration of non-state organizations. NGOs are required to register with the district authorities and, if health-related, the DDHS should formally recognize/approve their plans. The DDHS can request organizations to establish their programs in certain camps that are underserved and stresses the importance of sharing program planning and budget information. During an interview for this case study, the DDHS indicated that the overall level of information sharing from organizations implementing health services is not adequate and that his office's efforts to harmonize NGO activities with the district have been met some level of resistance.

Among those organizations that do work directly with district technical departments, different partnership models are used. For example, UNICEF in Gulu explained that the district implements about half of their health programs, while NGOs manage the other half. In working with the district, specific projects are first outlined annually in a joint work plan that is the result of a consultative planning process between UNICEF and the district. Typically, UNICEF tries to address gaps that are noted in the District Development Plan and then provides technical support during the district's project implementation. The UNICEF-Gulu office noted that the district is their main implementing partner and that they would wish to channel more of their funds directly through the district. However, district absorptive capacity and administrative processing speed are challenges, particularly in the emergency context.

CARE (USA) uses a different approach whereby there is a tripartite agreement between themselves, the district health services, and a community-based organization that provides clinical health services through its own staff (clinical officers, social workers, and environmentalists) working in district health units. The DDHS and DDMC offices together identify in which camps the interventions should be established (10 in Gulu, 5 in Pader). The community-based organization staff are then placed in specific health units, deployed by the district, but paid for by CARE. They are typically placed in the more remote IDP camps and are paid higher salaries relative to the district. While this approach may have inherent sustainability concerns, it does get staff into health units that are otherwise underserved.

The Uganda Program for Human and Holistic Development (UPHOLD) addresses community needs through a small grants program for health, education, and HIV/AIDS that channels funds to both the district health department and civil society organizations. The proportion that the district currently absorbs is relatively small and has been programmed for activities in the home-based management of fever, routine immunization, and "child days" mass immunizations. Absorptive capacity and reporting speed were described as being problematic.

3.3 Dealing with key trade-offs: saving lives vs. building capacity

Another coordination constraint lies in the divergence of opinion and operational models that different stakeholders use based on their perceptions about whether the situation in northern Uganda constitutes an "emergency" and whether to work through the pre-existing district health systems or through the creation of parallel service delivery structures. A spectrum of approaches exists, typical of many protracted emergency settings. At one end there are those within the international organizations that find the district system too slow, bureaucratic, and poorly staffed to accomplish their objectives. During discussions in the field, those functioning from a strictly humanitarian approach voiced the opinion that their job is to save lives and that if the government has the capacity to participate in that effort this is welcomed, but if not, the international organizations should be given the latitude to carry on with their work and get the job done. At the other end of the spectrum are those organizations that channel all of their efforts through the district systems. While acknowledging the challenges this entails, those engaged in this approach believe that the only sustainable way to deal with such a situation is

through sustained support to local systems. Within northern Uganda, different international organizations have used both strategies.

The government has not officially declared the situation in northern Uganda to be an emergency. Nevertheless, there is currently considerable debate among all stakeholders over the publication of a 2005 mortality study that the Ministry of Health and WHO conducted with contributions from a number of other international partners in IDP camps across Gulu, Kitgum, and Pader districts. The study initially revealed a mortality rate of over 1,000 excess deaths per week, indicating a serious humanitarian crisis. Although the report had been published with MoH approval, pressure from within the government led to a follow-up review by the Office of the Prime Minister, eventually resulting in an MoH retraction of the initial report findings. The MoH, WHO, and the International Rescue Committee undertook additional data analysis, and the excess mortality rate figure was revised slightly to about 900 excess deaths per week.

This report has generated a number of different reactions and continues to be debated today. Some have laid responsibility on the MoH and district health managers who, in turn, have increased calls for a better coordination of response. DfID increased its humanitarian funding to the North, in part at least to address the report, at the expense of budget support allocations. In essence, while the government calls for better coordination of efforts and the channeling of funds to the government (i.e., capacity building), donors and implementing agencies—especially those that are emergency-oriented—want to see the mortality rates go down as quickly as possible and believe that the best way to do that is through direct interventions. Because of human resource capacity and absorption limitations within the districts, it is difficult to do both at the same time.

For those organizations that do implement activities through the district, there are challenges in terms of district administrative procedures, which can be slow, absorptive capacity, and reporting. Capacity-strengthening needs in district service delivery for health programming in northern Uganda are similar to those in the rest of the country, if more pronounced. One of the key issues repeatedly mentioned during field interviews was the insufficient number and inadequate cadre of staffing at the health units. While many health units are inadequately staffed throughout the country, conflict-affected districts are severely challenged to attract and retain even low-level staff. Concerns stem from the overall insecurity and lack of motivation. Health workers have been very reluctant to work in units that are far from the district municipalities that require staying in the camps, citing not only insecurity, but also a lack of accommodation and incentives. Many stakeholders suggested that a “top-up” salary incentive to health staff working in remote and potentially dangerous locations must be provided to attract staff. The MoH has not been able to do this although this strategy has been formally discussed. Three years ago, the MoH proposed this and set aside funding to do so, but was told by the Public Service Commission to hold off because they were working on a cross-sector strategy. This has never evolved and now, though the MoH would like to introduce this, as of July 1, they do not have the funding to support it.

3.4 Measures to ensure the participation of “clients” in needs assessment

In theory, community members can voice their needs through various mechanisms. All districts in Uganda have undergone a decentralization process that involves a leadership and council structure at three distinct levels (five levels exist in terms for administrative/geographic purposes; leadership is elected at three levels). These are the district, sub-county, and village levels. Government planning protocols require that village committees be established (village councils, chaired by an elected chairperson), assess their own needs, and forward their concerns to the sub-county structure, which then incorporates these into plans sent to the district level. According to field interviews, this system has largely fallen apart in the conflict-

affected districts. Since, in general, communities have been moved into camps en masse, many village and sub-county council structures continue to exist in theory. In practice, however, within the camp environment, these structures are described as weak and mainly serve a coordination function interfacing between NGOs and the community members rather than implementing a proactive planning process.

At the same time, camps also have a “camp commander” (a civilian that the community elects) and camp committees (by sector), but these do not get directly involved in project management. Rather, they help the UN and NGOs to implement specific activities and deliver assistance by organizing registration exercises, mobilize the community for NGO activities, and so on. Theoretically, the camp commander sits with the committees and camp zonal leaders for planning and takes the community concerns to the sub-county council within the camp. The extent to which this system occurs in a functional manner is not clear.

The 2004 National IDP Policy allows for the creation of sub-county disaster committees through which community needs can be voiced and brought to the DDMC. In coordination meetings, the DDMC puts forth community needs to the humanitarian organizations. It is not clear how well this is working in any of the camps/districts.

Some donors, UN agencies and NGOs are making a concentrated effort to strengthen local structures that can more effectively give voice to their communities. In Gulu district, the Agency for Co-operation and Research in Development (ACORD) received funding from Oxfam Netherlands and the EC for a Good Governance project that focuses on transparency, accountability, and legislation. ACORD targets the District Planning Unit and sub-county leadership for training on roles and responsibilities, as well as the planning process (PEAP). Project staff also work directly with community structures to sensitize community members about local government projects and services that they should expect. The project has also helped to establish “poverty resource monitors” at the sub-county level who function like community “watch dogs” to see what funding is being spent, accounted for, outputs, and so on at the sub-county level. Security and low literacy rates are noted by project staff as some of the practical challenges in project implementation.

A different approach to identifying and addressing community needs is the World Bank-supported NUSAF. NUSAF is a five-year, \$100 million program that began in March 2003. It operates in virtually all of the districts in the North from the northeast to West Nile and includes those districts affected by the LRA conflict. Various visible community level poverty challenges informed the program design including:

- Great vulnerability of communities (poverty)
- Minimal involvement of communities in the decision-making processes
- Inadequate mechanisms for keeping communities informed of development efforts in their areas
- General lack of community empowerment
- Low level of community trust in government systems/structures, weak service delivery systems (leading to [among other things] the evolution of indigenous CSOs at the community level, i.e., an opportunity to work directly with the community)

To address these observations, the NUSAF has four main community empowerment strategies:

- (1) Access to information;
- (2) Bottom-up accountability (holding local government responsible for service delivery);
- (3) Use of traditional structures as part of implementation modalities; and,

(4) Implementation of community initiatives through “direct community financing.”

To date, approximately \$52 million has been disbursed through community financing in projects that cluster around (1) small scale infrastructure; (2) vulnerable groups support; and, (3) community reconciliation and conflict management. While ensuring a community-based focus, the program also works through the district level local government systems that are involved in community project proposal appraisal, approval, financial communication, and monitoring. The handling of funds is the only function in which the district does not participate; funds are disbursed directly to individual community group bank accounts.

3.5 Supporting the provision of services to marginalized groups on a non-discriminatory basis

Although it can be argued that northern conflict-affected districts are, as a whole, marginalized in terms of service delivery due to the isolation and service delivery difficulties that the conflict has engendered, certain groups may be considered particularly vulnerable. These include:

- Communities located in geographically more remote IDP camps
- Former child soldiers/former abductees (including child mothers)
- Former adult soldiers
- War wounded
- Orphaned children and young adults
- Elderly/disabled

Primarily by specific individual projects, UN and NGO programming are addressing the special needs of groups such as these. There do not appear to be special government funds or structures by which the district technical leadership addresses such needs. In addition to thinking about the functions that government normally addresses (including primary health and education), there are significant additional concerns in terms of conflict-affected populations, including psychological rehabilitation, skills training (including agricultural skills), and income generation. There is concern among many that if these needs are not addressed now in a truly effective and cohesive manner (i.e., not small-scale piecemeal approaches as is currently the situation), marginalization of vulnerable groups in the northern districts could lead to further tensions, frustration, and perhaps further conflict. There is currently an opportunity for development efforts to address concerns that can impact future fragility. So far there are not strong indications that either the government or the international community is addressing this opportunity in a comprehensive manner through longer-term plans for the return of populations to their communities of origin.

3.6 Summary and Conclusions

Donors fund over half of Uganda’s national health budget and much of that comes through budget support under the SWAs that have been in place since 2001. There is no budget in the annual work plan to address the health needs of displaced populations per se, but conflict-affected districts receive funding through central transfers and special projects. It does not appear that funding to conflict-affected districts is less than in other districts, although there are other considerable challenges in delivery health services under the current circumstances. The Office of the Prime Minister, Department of Disaster Preparedness and Refugees has responsibility for addressing national policy issues with regard to displaced populations, but does not implement services activities.

At the central level, there has been limited harmonization of humanitarian program investments in health for the conflict-affected districts. To date, there has been more coordination than harmonization though new funding from DfID through UNICEF may serve to improve

harmonization of efforts, at least within the UN system. And Uganda is one of three pilot countries to adopt a cluster lead approach. Under the cluster lead approach, UNICEF will initially have responsibility for coordinating the health sector. It is hoped that this will improve harmonization of humanitarian activities in the North.

On the ground, the DDMC is responsible for coordinating information on humanitarian needs of the population and the responses of the myriad local and international organizations that are currently responding to them. There is a disparity in the number of organizations offering services across Gulu, Kitgum, and Pader districts, with Gulu having far more than either of the other two districts. This likely is the result of the earlier insecurity in Gulu and establishment of camps as well as the relatively better geographic accessibility that it enjoys over the other two locations. In the health sector, day-to-day interactions, coordination, and harmonization of activities between implementing organizations and the district depend greatly on the DDHS personality, with some being more directly involved than others in decision-making and control of activities. Over time, however, a patchwork of services have developed across the camps in each district reflecting the relatively slow evolution of the emergency situation in northern Uganda and the ad hoc nature with which the international community responded. In addition to the other service delivery management challenges typical of health units in Uganda, the government has a very difficult time attracting and retaining staff for posts in northern Uganda due to security concerns and the often-remote locations of postings. Many displaced persons receive their health and other services from the international community, which to some extent erodes the government's legitimacy in service delivery terms.

There is a dilemma facing stakeholders who seek to improve the health status of Ugandans living in the North. On the one hand, a recent WHO and MoH mortality survey indicates high excess mortality due to malaria, AIDS, and violence, which necessitates an emergency response. At the same time, there is need to work through local health systems to the extent possible. Local systems face absorption capacity limitations, are considered by some organizations to be too slow, and beholden to district administrative systems that can, at times, be political. Ultimately, investments in both emergency response and local system capacity building are needed.

4 Lessons Learned and Recommendations

4.1 Fragility and health service delivery

Insecurity dominates the fragile state-health services relationship in northern Uganda. During fieldwork, most people interviewed were of the opinion that without security, there cannot be effective service delivery and that this is a situation where the delivery of health services may contribute to stability but cannot create stability on its own. Ultimately, this region's stability is defined in terms of a final and lasting resolution to the conflict.

Fragility as embodied by the insecure environment impacts the delivery of health services, first through the physical relocation of populations. In as much as displaced populations are unable to move more than 1-2 kms outside the settlements, they are generally unable to use the health units of their original communities. Both the district and outside stakeholders (UN and NGOs) have responded through the establishment of health services within the IDP camps to the extent possible, but a number of functional problems exist in terms of an overall lack of health workers, lack of transport for referrals and outreach activities, and resource logistics problems. CORPS have been incorporated into VHTs, which exist in the conflict-affected districts as throughout the rest of the country. But training has varied across camps depending on the organizations present and the particular programmatic emphasis that each uses.

Because of these and other factors described above, government health service delivery to conflict-affected populations is weak, and much of the population does not see the government as an effective service provider. This further contributes to fragility as populations question the government's legitimacy that has failed both to fully protect them physically (i.e., security) and is unable to provide effective service delivery. This in turn may be related to a perception among many in northern Uganda of marginalization—both marginalization of northern populations at various levels including service delivery and marginalization of the conflict itself. Poor service delivery, though complex in underlying reasons, can only serve to reinforce this perception.

4.2 Health sector adaptations

In terms of government service delivery, the health sector's main adaptation, as in the other sectors, lies in the establishment of the DDMC and similar sub-county committees to respond to community needs. These are coordination bodies rather than service provider organizations but theoretically serve an important function. Within the overall timeframe of the situation in northern Uganda, this is a very recent innovation, and it is unclear how much impact it has had across the affected districts. Ultimately, if the DDMCs function as intended, they could have a very positive impact on the rational distribution of services across communities currently in camps and later during the return phase. As well, it is theoretically a mechanism through which services could be "branded" as government-approved thereby increasing the government's profile as the leading entity in the organization of services. Although the success of the DDMCs depends in large part on the capacity of those directly involved to lead local level coordination/ harmonization efforts and the support of other district actors, it is also greatly impacted by the extent to which external organizations, particularly the implementing partners, participate meaningfully in such efforts. This will require flexibility on the part of the donor organizations that sponsor implementing partners to undertake service delivery. More than that, it will require that donors ensure that implementing partners participate fully in these mechanisms.

Uganda lacks an effective, practical service delivery response mechanism for conflict-affected populations despite the facts that the conflict in the North has lasted 20 years and several other parts of the country have hosted refugee populations for almost as long. Ultimately, a national health sector policy and donor support for conflict-affected populations and other national

emergencies through national programming are needed. While this may take many years to elaborate, it is an important element of national development and is crucial for the government's long-term response capacity. Components of such a policy and programming options could address issues that today hamper service delivery in northern Uganda, including remuneration for health care workers in dangerous circumstances, expedited drug supply chains to the community level, referral systems, and coordination mechanisms.

4.3 Accessibility, availability, acceptability, and quality of services to marginalized groups

As described in this case study and other sources, much of the population in the northern conflict-affected districts lacks accessible health care services. Many households, especially those located in the most insecure areas, are geographically removed from health units and many health units lack even basic staffing. At the same time, it is believed that duplication of services in some areas appears to lead to inequitable access to health care across settlements. As noted above, UNICEF is leading a detailed mapping exercise after which it is expected that service-providing stakeholders will redistribute their efforts to improve service delivery equity especially in terms of geographic access.

There are also marginalized groups within the conflict-affected communities as described above (e.g., ex-combatants, former child soldiers, orphans, and so on) who may have special physical and mental health needs. Although these are theoretically catered to to some extent in the current national Health Sector Strategic Plan, currently international organizations mainly provide service delivery for vulnerable groups in what seems to be a piecemeal fashion at this time. A comprehensive strategy is lacking, through which the government health care providers and external organizations can together create a coherent approach among themselves.

4.4 Adaptations by international development partners

The main form of donor harmonization in health service delivery in Uganda is through SWAPs, which address the national health budget. The national health budget does not include specific allocations or harmonization for conflict-affected districts, although appropriate health service delivery in conflict and post-conflict situations is called for in the national Health Sector Strategic Plan II. In general, it seems that both the government and the donor community see large-scale funding for the North as an issue outside the regular set of operations, and therefore donors turn to their implementing partners with a variety of initiatives depending on what they determine are the priorities. If harmonization of development health sector funding has been challenging, it has largely not been attempted in response to the northern conflict within those same mechanisms.

Among the UN agencies, two possible adaptations are currently underway: (1) the joint UN agency proposal for programming in northern Uganda, managed by UNICEF and using funds from DfID and SIDA; and (2) the cluster lead approach, with UNICEF as the lead organization for health and nutrition.

The DDMC also represents an adaptation of sorts at the district level, though participation by the international development partners seems to be spotty, and it is unclear what impact it has been able to achieve in the health or any other sector.

Inasmuch as many donors have tried to strengthen the government's capacity to address health needs through a harmonized approach to funding the national health budget, it may be possible to create a special allocation for health service delivery for conflict-affected populations and increase harmonization among donors for the long-term needs in the North. If so, additional technical support to the government may be necessary since national level response mechanisms do not exist, and the district systems suffer from absorption capacity limitations. To

avert further health crises in the more immediate term, donors will have to continue channeling funds through the UN and NGOs. As noted above, implementing partners must support the government's attempt to create a coordinating mechanism within the DDMC through meaningful participation.

4.4 Promising coalitions for improved service delivery

Perhaps the most promising improved service delivery coalition in the short term consists of the community health workers through the CORPS and VHT that collaborate with both the district health services and the UN and NGOs. As WHO continues its efforts with the Ministry of Health to standardize training through the production of a comprehensive set of guidelines and training modules, this may address what until now has been described as the piecemeal approach of international organizations working with the CORPS and/or VHT. At one level, this may prove to be an important stopgap measure to reach communities in more remote and under-served areas. At the same time, these mechanisms are intended to be effective health development partners for both the local health services and international implementing organizations for the longer term.

4.5 Cross-sectoral synergies

At this time, the piecemeal approach is the chief characteristic of service delivery in the camps. This applies to sectoral coverage as well as geographic coverage. UN programs such as UNICEF address multiple sectors, but on the ground it seems many implementing partners address needs according to their individual strategies. Individual NGOs may see cross-sectoral synergies within their own programs at those locations where they operate, and there may be coordination among multiple NGOs involved in various sectors within one location, but there does not seem to be a cohesive plan to ensure that each camp is receiving full service delivery either by one or multiple NGOs. The DDMC is intended to help improve service coverage and improve cross-sectoral synergies, but some committees function better than others, and impact is likely quite uneven.

4.6 Service delivery findings and the “Principles for Good International Engagement in Fragile States”

In general, the findings of this case study lend themselves well to analysis through the “Principles for Good International Engagement in Fragile States.” At an overall level, these principles call for states’ durable responses to be “. . . driven by their own leadership and people.” One theme echoed several times in the Uganda case study is a lack of national response capacity and consequent “ownership” of the situation in the North by the international community. While national-level and district capacity to address the service needs of conflict-affected populations do not currently match needs, these must be effectively supported through programs and policies that explicitly seek to build them to every extent possible. Further observations on each of the principles are offered below:

(1) *Take context as the starting point.* As noted at the beginning of this case study, Uganda may be considered a stable country with pockets of fragility that negatively impact security, drain economic resources, and undermine service delivery. Both national and district-level capacities to address the consequences of 20 years of civil conflict and breakdown are inadequate. There is a limited national humanitarian response capacity in general and district service delivery systems that have been seriously impacted by insecurity. The question of political will in the Uganda context is complicated. On the one hand, there are arguments on both sides as to whether or not there is a basic unwillingness to end the conflict militarily. At the same time, the marginalization of the conflict in general as an “Acholi issue,” and the lack of a

national budget allocation to address the social service needs of the displaced after many years of conflict could also be interpreted as a disinterest in the population's needs. Moving forward, what may be most important in this context is the population in the North's perception of how they view the government's willingness to address their needs. Through the recent presidential elections, northern communities have demonstrated that they have limited, if any, faith that the current government has their best interests at heart.

(2) *Move from reaction to prevention.* To a large extent, current programming for northern Uganda is reactionary. Last year's WHO/MoH mortality study, though controversial, is an indication of failure on the part of both the government and the international community even to react to the situation adequately. At this time, when it appears likely that the conflict is finally in a wind-down stage, it is important to start thinking about what the currently displaced populations will need to return home. District-level mechanisms should be strengthened to prepare for this eventuality, and yet their partner humanitarian organizations do not seem to be geared towards the next phase. Planning now for relocation whenever it occurs can position stakeholders in a proactive rather than reactive situation and may prevent what otherwise may be a highly problematic transition in service delivery terms.

(3) *Focus on state building as the central objective.* According to this principle, state building is based on: (1) the capacity of state structures to perform core functions; (2) their legitimacy and accountability; and (3) the ability to provide an enabling economic environment. Although it is difficult to focus effectively on state building and an emergency response at the same time, Uganda provides a compelling opportunity to do so. It is already a relatively strong state, although unresolved conflict and underlying issues in the North threaten its stability and long-term growth. The government's lack of capacity to address the humanitarian needs of its population in the North calls into question its legitimacy from the perspective of northern population. Because marginalization of the Acholi people has been identified as one of the drivers of fragility in this context, it is critical that the government's national response be both genuine and clearly identifiable. This will require state building or, more specifically, the building of state systems to respond to humanitarian needs in this area. The National IDP Policy is a positive step in this direction within the policy arena; the international community needs to support this policy as the basis of reality programming.

(4) *Align with local priorities and/or systems.* Most major donors have made significant efforts in this area through the implementation of SWAps in both the health and other sectors. The country is well along the way to a harmonized health planning system in this respect. Nevertheless, there remain opportunities for more complete alignment in, for example, providing information in appropriate budget years and classifications, as noted in the principles. This does not yet happen with all donors. In addition, there is not yet a harmonized approach to special needs funding for northern Uganda. As described above, a large DfID-sponsored program for the North will be underway soon, designed with the intention of creating a coordinated approach to implementation at least among the UN agencies. However, a donor-wide system of responding to the North is not yet in place. It is anticipated that the Joint Country Coordination and Monitoring Committee on Northern Uganda (described in section 2, above) and a specific allocation to northern Uganda through the MTEP (2006/07–2008/09) could help to formalize an alignment in this area. The key to success is the translation of donor harmonization, especially in the humanitarian arena, into coordinated programming by the partners.

(5) *Recognize the political–security–development nexus.* While all stakeholders doubtless recognize the political–security–development nexus, it is not clear whether there is one common framework for analyzing each individual donor's policies and/or multiple donors' policies for coherence. It is possible that the transitional results matrix or other tools could assist the

government and donor planners in thinking about the impact of their current and intended strategies.

(6) *Promote coherence between donor government agencies.* While the case study did not specifically analyze in-depth the internal coherence of different donor strategies in terms of political, security, economic, and social spheres, there was a chance to become generally familiar the USAID program strategy. It may well be one of the more comprehensive government responses in that all the listed areas are addressed in some way. USAID addresses political concerns through its democracy and governance programs, which focus on effective governance, accountability and legislative oversight, political pluralism, district-level management, and informed civil society participation in national and local governance processes. Another one of the agency's key strategies focuses on economic growth, in particular food security and sustainable agriculture, environmental degradation, trade and investment. USAID's human capacity investments in health and education address social sphere objectives (USAID 2006). In addition to these programs, the Department of Defense provides various forms of security support and liaises with USAID on the issue of improved army–civilian relations.

(7) *Agree on practical coordination mechanisms between international actors.* With regard to programming in the North, this is occurring to some extent at both the national and district levels as described above, though not optimally. These meetings are mainly for information-sharing coordination rather than the harmonization of work plans or activities. These mechanisms do involve national and/or district level government and are usually chaired or co-chaired by the government. The anticipated JCCMC and cluster lead approach described in sections 2 and 3, above, are intended to improve the practical coordination both among international actors and between international actors and the government.

(8) *Do no harm.* This principle specifically notes that among other potential harms, donors should not bypass national budget processes that can undermine planning capacity. As described in section 3, budgeting for development health activities occurs through the SWAps for most major donors. The Annual Health Sector Performance Report for 2004/2005 expresses that, more than anything, timely budget information is needed. If planning calendars are not in some way harmonized, the MoH will not know in advance how much or which programs will be funded. Similarly, if district authorities do not receive sufficient information from other stakeholders about the size, scope, and budget of their field activities, it is hard for them to budget true needs or to know which areas are under-served. Along these lines, one of the largest possible harms in the context of northern Uganda is the irrational distribution of services, as described.

Another example under this principle involves donor support for staff salaries that are higher than what the government can afford to pay. Among various international organizations supporting health service delivery in the North, some do pay for health staff salaries and are paying above the standard remuneration policies to attract and retain staff in remote areas. This is recognized as unsustainable by at least one donor/implementer that is looking for ways to discontinue the practice.

(9) *Mix and sequence aid instruments to fit the context.* The health budget has not increased in the past three years, and current government contributions are less than half of the total health budget. According to the Annual Health Sector Performance Report for FY 2004/2005, analysis of donor project expenditures indicates that the majority of spending (56%) in the last financial year was spent on inputs that do not figure in the Health Sector Strategic Plan priorities. Thirty-one percent was spent on recurrent costs including 4 percent for Ugandan health staff, 20 percent for medicines and medical supplies, and 7 percent for other recurrent

costs. Capital costs included both infrastructure (9%) and non-infrastructure (4%). The Ministry calls for additional analysis of donor projects in general to ascertain whether or not they actually fit into the country's identified health sector priorities (MoH 2005c). This type of analysis is not currently available for health or other sector spending for northern Uganda. As indicated earlier, UNICEF is currently undertaking a mapping of services that is the first attempt to determine the level and focus of government and donor investments in the area. It is possible that in some of the conflict-affected districts there is also an idea of these trends through the DDMC, albeit most likely not fully complete due to mixed participation of the humanitarian assistance actors in that forum.

(10) and (11) *Act fast . . . but stay engaged long enough to give success a chance.* These two points are linked to the challenge of providing both humanitarian and development assistance concurrently. Looking at the situation in the North, where the majority of those living in camps are dependent on food aid and health indicators clearly signal an emergency, it is clear that the donor community needs to continue significant humanitarian assistance funding. With security improvements, this is also an appropriate moment to start planning for the return of IDPs to their communities of origin. Ideally, assistance can be channeled through local government systems, but where this cannot now be done effectively enough to save lives, it should continue to be programmed through the UN and NGOs. In tandem, the donor community also needs to invest as much as possible in the district health systems, not only channeling funds through that system but also providing technical support as necessary or possible. These systems have been challenged by years of war, and various aspects—especially the health human resource base—are in need of long-term support. Donors should encourage public service reforms that can help address such challenges from within the local systems.

(12) *Avoid pockets of exclusion.* While this principle is written as applied to countries as a whole, it is also relevant when thinking about northern Uganda. It is already known that certain camps, particularly those that are most secure and most accessible geographically, are better served by government and NGO services than those that are more remote. The ongoing service delivery mapping exercise will help point out which camps are most over/underserved, and it is anticipated that this will allow for a rational reallocation of donor resources.

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